MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5825

CERTIFICATE OF DEATH

05793

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: about 20 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 557 Girard Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): 24 Havre de Grace
d. STREET ADDRESS: 1557 Girard Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gladys Middle: B. Last: Brooks

4. DATE OF DEATH: Month: May Day: 8, Year: 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 12, 1923
9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months: 11 Days: 26
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse Maid
10b. KIND OF BUSINESS OR INDUSTRY: Private Family
11. BIRTHPLACE (State or foreign country): Liberty Grove, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Morris N. Boddy
14. MOTHER'S MAIDEN NAME: Mary Jane Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-12-9268
17. INFORMANT: Mrs. Vivian Henry, Address 557 Girard St. Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of the Lung
DUE TO
(b): Carcinoma of the Breast
DUE TO
(c):

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 14, 1960, to May 8, 1960, that (I) (we) last saw the deceased alive an May 8, 19 60 and that death occurred at 5:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/10/60
22c. PHYSICIAN'S NAME (Type): George T. Stansbury, M. D.
22d. ADDRESS: 569 Revolution St., Havre de Grace Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 12, 1960
23c. NAME OF CEMETERY OR CREMATORY: Mt. Zora Cemetery
23d. LOCATION (City, town, or county) (State): Conowingo Cem Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Elmer E Bullock, Havre de Grace, Md.
ADDRESS 556 Lewis St.
25a. REC'D BY REGISTRAR DATE MAY 12 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5826 — 05794 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air
d. STREET ADDRESS: RD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Glenn — Middle: Roland — Last: Carter
4. DATE OF DEATH: Month: May — Day: 9 — Year: 19-0

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-8-51
9. AGE (If under 1 year last birthday): 8 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School
10b. KIND OF BUSINESS OR INDUSTRY: Student
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Guy Carter
14. MOTHER'S MAIDEN NAME: Gloria Conlson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr. Guy A. Carter — Address: R.D. #2 Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH
813X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Contusion heart
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto - bicycle type
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: 5-7 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rte 543 Wheel
20f. (City or town): Rd. nr Fountain Green (County): Harf. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-9-60
EXAMINER'S NAME (Type): G. Gerald C Palmer M.D. — Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 11, 1960
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air, Harford Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway & Williams St, Bel Air, Maryland
24a. REC'D BY REGISTRAR — DATE: MAY 11 '60
24b. REGISTRAR'S SIGNATURE: [illegible] S. Turner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5827 Items 10,11,12,15 FilmG264 6-6-60 et

05795
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Joppa
d. STREET ADDRESS Route 7
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Simon Middle Kaggise Last Clapper
4. DATE OF DEATH Month May Day 22 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-28-80
9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hopewell, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Clapper
14. MOTHER'S MAIDEN NAME Nancy Kaggise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218 36 0562
17. INFORMANT Address Mrs. Clapper Joppa Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C Palmer MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-23-60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 25, 1960
22c. NAME OF CEMETERY OR CREMATORY Mountain Christian
22d. LOCATION (City, town, or county) Joppa (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE W A Archer ADDRESS Benson, Md
24a. REC'D BY REGISTRAR DATE MAY 31 '60
24b. REGISTRAR'S SIGNATURE Clifton S. Knauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5843

05796 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt. 3; Box 36

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air
d. STREET ADDRESS: Rt. 3, Box 36
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Henrietta; Middle: Troup; Last: Dentry

4. DATE OF DEATH: Month: May; Day: 21; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Nov. 7, 1862

9. AGE (In years lost birthday): 97 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: August Dames

14. MOTHER'S MAIDEN NAME: Elizabeth Posliff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Henry A. Dentry — Address: Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
DUE TO
(b): Chronic Cardio-Vascular Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hiatal Hernia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1, 1958, to May 21, 1960, that I last saw the deceased alive on May 19, 1960, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Willard P. Hudson M.D. — May 21, 1960

PHYSICIAN'S NAME (Type): Willard P. Hudson M.D. — Forest Hill, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/24/60

22c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

22d. LOCATION (City, town, or county) (State): Long Green, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tichnor & Sons - Bel Air, Md.

ADDRESS:

24a. REC'D BY REGISTRAR DATE: MAY 24 '60

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05797

5828

CERTIFICATE OF DEATH

Item 7 Film G263 5-24-60 et

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 10 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 642 N. STOKES, ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 HAVRE DE GRACE
d. STREET ADDRESS: 642 N. STOKES, ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STEPHEN Middle THOMAS Last DUBREE

4. DATE OF DEATH: Month MAY Day 10 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 21, 1881

9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ARTHUR DUBREE

14. MOTHER'S MAIDEN NAME: ELLEN SINGLETON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ___ (If yes, give war or dates of service) ___

16. SOCIAL SECURITY NO.: 212-16-0421

17. INFORMANT: Address: Mrs. Myrtle L. Elliott, Havre de Grace, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if ony, which gave rise to immediate cause (a), stoting the underlying cause last.

DUE TO (b): Hypertensive-Arteriosclerotic Heart Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Yeor 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11/10/59 19__ to 5/10 1960, that (I) (we) last saw the deceased alive on May 9, 1960, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/11/60

22c. PHYSICIAN'S NAME (Type): George T. Stansbury, M. D.

22d. ADDRESS: 569 Revolution Street Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 13, 1960

23c. NAME OF CEMETERY OR CREMATORY: ROCK RUN CEM.

23d. LOCATION (City, town, or county) (State): HARFORD MD

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: R. Madison Mitchell, Havre de Grace, MD.

25a. REC'D BY REGISTRAR DATE: MAY 13 '60

25b. REGISTRAR'S SIGNATURE: Clifton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

Items 20,21 Film 263 5-31-60 ors

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5829 Item 8 Film G263 5-23-60 et 05798

FOR STATE HEALTH DEPT.

TO DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
   d. STREET ADDRESS: 1 Toll Gate Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: TOMMY — Middle: HALL — Last: DYSON

4. DATE OF DEATH: Month: May — Day: 16 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 31 1929 (1941)

9. AGE (In years last birthday): 30 (28) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Exterminator

11. BIRTHPLACE (State or foreign country): Tenn

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 411-46-2340

17. INFORMANT: Mrs Elizabeth C Dyson — Address: Toll Gate Road Bel Air Md Rural

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gunshot wound of right temple, near-contact — INTERVAL BETWEEN ONSET AND DEATH

976X

Conditions, if any, which gave rise to immediate cause (a), steting the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.): Shot self in head

20c. TIME OF INJURY Hour: 5 p.m. — Month, Day, Yeer: 5/16/1960

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.): Home

20f. (City or town): Bel Air — (County): Harford — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W Bradley King Jr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 5/17/60

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 19/60

22c. NAME OF CEMETERY OR CREMATORY: Oak Grove Baptist

22d. LOCATION (City, town, or country): (Bel) Air Rural (State): Md

23. FUNERAL DIRECTOR — ADDRESS: Joseph T Gates & Son Bel Air Md

24a. REC'D BY REGISTRAR — DATE: MAY 19 '60

24b. REGISTRAR'S SIGNATURE: Cristina E. Kruse

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5830 — Reg. Dist. No. 05799

1. PLACE OF DEATH
a. COUNTY: ~~Carroll~~ Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace ~~Conowingo~~
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo 07X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle A. — Last Fogus
4. DATE OF DEATH: Month May — Day 15 — Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 4/1/1914
9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Contracting
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Ernest Fogus
14. MOTHER'S MAIDEN NAME: Blanche Byers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 284-20-56
17. INFORMANT — Address: 23 Mrs Carter Burdette, White Sulphur Springs W. Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH: —
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b): 819 X — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Auto accident auto-object-type
20c. TIME OF INJURY: Hour 4:30 o. m. p. m. — Month, Day, Year 5-15 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Bridge
20f. (City or town) Conowingo (County) Cecil (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED: 5-15-60
EXAMINER'S NAME (Type): Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — Bel Air Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/19/60
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.
22d. LOCATION (City, town, or county) Colora Cecil (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ralph M Reed, Rising Sun, Md.
24a. REC'D BY REGISTRAR — DATE: MAY 19 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5844 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05800

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill
c. LENGTH OF STAY IN 1b: 16 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Forest Hill
d. STREET ADDRESS: Coopstown Rd
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Coopstown Rd.

3. NAME OF DECEASED (Type or print): First John Middle Ellis Last Folberth

4. DATE OF DEATH: Month May Day 27 Year 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1943

9. AGE (In years last birthday): 16 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gustave William Folberth

14. MOTHER'S MAIDEN NAME: Marie Costello

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mr. Gustave William Folberth same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphixia by drowning — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
DUE TO (c):

929.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Learn to swim & drowned

20c. TIME OF INJURY Hour 4 p. m. Month, Day, Year 5-27 19 60

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm Pond

20f. (City or town) Forest Hill (County) Ha (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C Palmer-MD

Bel Air, Md DATE SIGNED 5-27-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/31/60

22c. NAME OF CEMETERY OR CREMATORY: Belair Memorial

22d. LOCATION (City, town, or county) (State): Belair, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leonard J. Ruck 5305 Harford Road #14

24a. REC'D BY REGISTRAR DATE: MAY 31 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5845 Item 9 Film 264 6-13-60 et 06946

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bel Air Rural
c. LENGTH OF STAY IN 1b: 21 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air Rural
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
RONALD Lee		HAWKS	May	31	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		Jan. 9, 1936	24 23 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm hand	Farm	Carroll County, Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edgar Paul Hawks	Jesabell Midkill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	184-36-52	Edgar Paul Hawks	Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple and extensive skull fractures — INTERVAL BETWEEN ONSET AND DEATH

98 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Blunt-force injury of skull with multiple individual blows

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2De. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Multiple blows to head

20c. TIME OF INJURY Hour a.m. p.m. / Month, Dey, Yeer	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
February 60		Unknown	Presumably Bel Air Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: W. Bradley King, Jr. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

Address (Street, city, town, or county):

DATE SIGNED: 6/1/60

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	6/7/1960	Oak Grove	Churchville Md.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Vernon E. McMullen	Pershing Lane, Md.	JUN 9 '60	Eustace S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5831 **CERTIFICATE OF DEATH** 05801

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Street
d. STREET ADDRESS R. D. 1
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print) First: JESSE Middle: FRANK Last: Huff

4. DATE OF DEATH Month: May Day: 20 Year: 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 4, 1885
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agriculture
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Street, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George T. Huff
14. MOTHER'S MAIDEN NAME: Rebecca P. Guiton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-36-2836
17. INFORMANT: Mrs. Anna Dunnigan Huff Address: R.D. #2 Street, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b) Arteriosclerotic Cardio Vascular — 10 yrs
DUE TO (c) disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1946, to May 20, 1960, that I last saw the deceased alive on May 20, 1960, and that death occurred at 1 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Dudley Phillips M.D. ADDRESS (Street, city or town, state) Darlington Md DATE SIGNED 5/20/60

PHYSICIAN'S NAME (Type) Dudley Phillips

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 24, 1960
22c. NAME OF CEMETERY OR CREMATORY Emory Methodist Cemetery
22d. LOCATION (City, town, or county) (State) Street, Harf. Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE MAY 25 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5832

CERTIFICATE OF DEATH

05802
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 12 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PA. b. COUNTY: YORK ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELTA 75X-3
d. STREET ADDRESS: MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSPITAL

3. NAME OF DECEASED (Type or print): First IDA Middle MAY Last KILBURN

4. DATE OF DEATH: Month MAY Day 14 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 12, 1898

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): HARFORD Co. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES A. FINDLEY

14. MOTHER'S MAIDEN NAME: ELIZABETH HERMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: J. EARL KILBURN Address: DELTA, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric + Illiac Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO (b): Diffuse meta static Carcinoma — 6 mos.
DUE TO (c): Edema - carcinoma, rt ovary — 2 yrs

175.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1974 to May, 1969 that I last saw the deceased alive on May 14, 1960, and that death occurred at 3:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: J Ralph Horky — ADDRESS (Street, city or town, state): Churchville Md — DATE SIGNED: May 14

PHYSICIAN'S NAME (Type): J Ralph Horky MD — Churchville Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAY 17, 1960

22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET

22d. LOCATION (City, town, or county) (State): FAWN TWP., YORK CO., PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbaugh ADDRESS: DELTA, PA.

24a. REC'D BY REGISTRAR DATE: MAY 17 '60

24b. REGISTRAR'S SIGNATURE: Clarence L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5833 — 05803 — Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 18 years

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
o. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Havre de Grace

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital
d. STREET ADDRESS: 1 Carlton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charlie Middle A Last Kilgore
4. DATE OF DEATH: Month May Day 9 Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-17-07
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: HARFORD METAL
11. BIRTHPLACE (State or foreign country): KENTUCKY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Newton Kilgore
14. MOTHER'S MAIDEN NAME: UNK.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Carrie M. Kilgore — Address: Carlton Road RR#2 Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): G S W Abdomen — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
919.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Cleaning gun + it went off + shot him
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Havre de Grace (County) Ha (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Bel Air Md — DATE SIGNED: 5-9-60
EXAMINER'S NAME (Type): Gerald C. Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 13 1960
22c. NAME OF CEMETERY OR CREMATORY: BEL AIR MEMORIAL GARDENS
22d. LOCATION (City, town, or county): BEL AIR (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace Md.
24a. REC'D BY REGISTRAR DATE: MAY 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5834

CERTIFICATE OF DEATH

05804
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 12 days.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRYVILLE 07X-2
d. STREET ADDRESS: SUSQUEHANNA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle L. — Last KREIDER

4. DATE OF DEATH: Month MAY — Day 27 — Year 1960

5. SEX: Male
6. COLOR OR RACE: Wh.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 5/1/73
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): P.R.R. Conductor
10b. KIND OF BUSINESS OR INDUSTRY: Freight
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Wilton Kreider — Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): Hypertensive + arteriosclerotic
DUE TO (c): Cardiovascular Disease — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Pneumonitis — left lower lung field.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 15, 1960, to May 27, 1960, that I last saw the deceased alive on May 27, 1960 and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C. Lee, M.D. — ADDRESS (Street, city or town, state): 711 N. Union Ave. — DATE SIGNED: 5/27/60
PHYSICIAN'S NAME (Type): Edward C. Lee, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-29-1960
22c. NAME OF CEMETERY OR CREMATORY: Principio Cemetery
22d. LOCATION (City, town, or county) (State): Principio Furnace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Eva Patterson & Son — ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: MAY 31 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5835 — 05805 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md — b. COUNTY: ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harmede Grace
c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01.4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital
d. STREET ADDRESS: 242 Washington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ambrose — Middle: D. — Last: Lewis
4. DATE OF DEATH: Month: May — Day: 25 — Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 9, 1937
9. AGE (In years last birthday): 22 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: A. Bauer & Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Lewis
14. MOTHER'S MAIDEN NAME: Helen C. Bauer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Helen C. Lewis — Address: 242 S. Washington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH:
902.8
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell from rock
20c. TIME OF INJURY Hour: 8 p. m. — Month, Day, Year: 5-25 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rocks State Park
20f. (City or town): Rocks (County): Harford (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Bel Air Md. — DATE SIGNED
EXAMINER'S NAME (Type): Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 5-26-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-30-1960
22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Lilly & Zeiler Inc. 1901 Eastern Ave.
24a. REC'D BY REGISTRAR DATE: MAY 31 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DE... MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please exe... cute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05806

5846 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa
c. LENGTH OF STAY IN 1b 5yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allen Cabin Town

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Joppa
d. STREET ADDRESS 1 Allen Cabin town
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First James Middle W. Last McDairmant
4. DATE OF DEATH Month May Day 13 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 7-31-1899
9. AGE (In years last birthday) 60 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber
10b. KIND OF BUSINESS OR INDUSTRY ___
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas McDairmant
14. MOTHER'S MAIDEN NAME Anna Franke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI
16. SOCIAL SECURITY NO. 216-12-8592
17. INFORMANT Address Mrs Frances Farria 1051 church ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) ___
DUE TO (c) ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒; Inquiry ☐, and find that death resulted from: Natural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Gerald C. Palmer M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Bel Air MD, 5-13-60
EXAMINER'S NAME (Type) Gerald C. Palmer M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5-17-60
22c. NAME OF CEMETERY OR CREMATORY Bal To. National Cemetery
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens ADDRESS Funeral Home, Inc 1501 E. Fort Ave.
24a. REC'D BY REGISTRAR DATE MAY 19 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5835 — 05807

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Rocks
d. STREET ADDRESS: / Seven Cedars Apts.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert W. — Middle: — Last: Osgood
4. DATE OF DEATH: Month: May — Day: 21 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 21, 1935.
9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Warren C. Osgood
14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 018 28 0682
17. INFORMANT — Address: Official U.S. Army Records. Aberdeen Prov. Grds.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Electrocution — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

914.3 ✓

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Touched bare wires while making electrical connexion
20c. TIME OF INJURY — Month, Day, Year: Hour a.m. xxx 2:30 May 21 1960
20d. INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): dairy
20f. (City or town) (County) (State): Churchville Harford Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Charles S. Petty
Address (Street, city, town, or county):
DATE SIGNED: 22 May 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5-23-60
22c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus.
22d. LOCATION (City, town, or country) (State): Chicipee Falls, Mass.

23. FUNERAL DIRECTOR — ADDRESS: Wm. Cook Flight Inc. 6009 Harford Rd. 14.
24a. REC'D BY REGISTRAR: MAY 25 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05808

5824

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
c. LENGTH OF STAY IN 1b: 18 MOS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 116 LAW. ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 HAVRE DE GRACE
d. STREET ADDRESS: 414 BOURBON, ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle HAYS Last RAUSCHER

4. DATE OF DEATH: Month May Day 3 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 27 1873

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDERICK HAYS

14. MOTHER'S MAIDEN NAME: SUSAN HESS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: J. VERNON RAUSCHER Address: 414 BOURBON, ST. HAVRE DE GRACE MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriosclerotic CV Disease — 8 yrs
DUE TO (c): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June 19 42 to May 19 60 that (I) (we) last saw the deceased alive on May 3 19 60, and that death occurred at 7 P. M, from the causes and on the date stated above.

22a. SIGNATURE: J Ralph Hadley M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: May 6, 1960

23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL

23d. LOCATION (City, town, or county) (State): HAVRE DE GRACE MD.

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE MAY 9 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05809

5847

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 34 Swan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PHYLLIS — Middle MARIE — Last RICE

4. DATE OF DEATH: Month May — Day 26 — Year 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 23, 1960

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months — Days 3 — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest Odell Rice Sr

14. MOTHER'S MAIDEN NAME: Ellie Austria Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): N o
(If yes, give war or dates of service): N/A

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Father
Address 34 Swan Street Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Apnea neonatarum — INTERVAL BETWEEN ONSET AND DEATH: 5 min
762.5
DUE TO (b): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 23, 1960 19____, to May 26, 19 60, that I last saw the deceased alive on May 26, 19 60, and that death occurred at 11:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas Fraher Capt MC, MD
ADDRESS (Street, city or town, state): US Army Hospital Aberdeen Proving Ground, Maryland
DATE SIGNED: 26 May 60
PHYSICIAN'S NAME (Type): THOMAS FRAHER, Capt MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/27/60
22c. NAME OF CEMETERY OR CREMATORY: Post cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen Prov. Gr. Md

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Farring
ADDRESS: Aberdeen Md

24a. REC'D BY REGISTRAR DATE JUN 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

2 0 5 0 2 0 3 X V 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5837

CERTIFICATE OF DEATH

05810
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air
d. STREET ADDRESS: RD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rebecca — Middle: Jane — Last: Riley

4. DATE OF DEATH: Month: May — Day: 19 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 1, 1889
9. AGE (In years lost birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Rose
14. MOTHER'S MAIDEN NAME: Virginia Myrse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Glenn Riley — Address: Bel Air, R.D., Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO (b): Arteriosclerotic - C-V Disease — 6 yrs
DUE TO (c): Diabetes Mellitus — 16 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Duodenal Ulcer, Diverticulitis, Hypertrophic Arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1945, to May, 1960, that I last saw the deceased alive on May 19, 1960, and that death occurred at 8:14 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Ralph Horky, M.D. — ADDRESS (Street, city or town, state): Churchville — DATE SIGNED: May 20

PHYSICIAN'S NAME (Type): J. Ralph Horky — Churchville Md.,

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: May 20, 1960
22c. NAME OF CEMETERY OR CREMATORY: SCOTT Funeral Home
22d. LOCATION (City, town, or county) (State): RICHLANDS Tazewell Co., Va.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard L. McComas — ADDRESS: Abingdon, Md.,
24a. REC'D BY REGISTRAR DATE: MAY 23 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05811

5848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dublin
c. LENGTH OF STAY IN 1b 9 weeks
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia
b. COUNTY Galax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galax 83X-3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Ida Middle: Sexton Last:

4. DATE OF DEATH Month: May Day: 23 Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 13 Dec 1882

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Wyth Co, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Montgomery Cregger

14. MOTHER'S MAIDEN NAME: Sarah Ackers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Daughter - Mary Simms - Address: Dublin Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(b) Arteriosclerotic cardiovascular disease & congestive failure — 3 month. +
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonitis mild

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 April, 1960, to 23 May, 1960, that I last saw the deceased alive on 21 May, 1960, and that death occurred at 1:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin W. Whitefoord M.D. M.D. ADDRESS (Street, city or town, state): Whiteford Md DATE SIGNED: 23 May 60

PHYSICIAN'S NAME (Type): Edwin W. Whitefoord, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: May 25, 1960

22c. NAME OF CEMETERY OR CREMATORY: Hillsville Va

22d. LOCATION (City, town, or county) (State): Hillsville Va

23. FUNERAL DIRECTOR'S SIGNATURE: H. D. Bosley ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR DATE: MAY 26 '60

24b. REGISTRAR'S SIGNATURE: Andrew J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5833 — 05812 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XBelcamp
d. STREET ADDRESS: Box 282
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Mathew Last Stevenson
4. DATE OF DEATH: Month May Day 17 Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 22, 1936
9. AGE (If over 1 year last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Bata Shoe
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James T. Stevenson
14. MOTHER'S MAIDEN NAME: Ella Hayton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 231-44-2318
17. INFORMANT: James T. Stevenson, Address Box 424, Tazewell, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture ~~Skull~~ pelvis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
819X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rupture urinary bladder
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident with fixed object
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: 5-7 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Havre de Grace (County) Harf. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Bel Air, Md DATE SIGNED 5-17-60
EXAMINER'S NAME (Type): Gerald C Palmer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/20/60
22c. NAME OF CEMETERY OR CREMATORY: Appalachain Mem. Cem.
22d. LOCATION (City, town, or county) (State): Tazewell, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: MAY 19 '60
24b. REGISTRAR'S SIGNATURE: Cirthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5849 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05813
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Hanford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): High Point Road

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Hanford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Benjamin Middle Stewart Last
4. DATE OF DEATH: Month May Day 24 Year 1960
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 10, 1910
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Labor
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Mill
11. BIRTHPLACE (State or foreign country): Forest Hill, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Howard W. Stewart
14. MOTHER'S MAIDEN NAME: Mary Rebecca Kell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-07-8373
17. INFORMANT: Address: Mrs. Agnes Robinson, Forest Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 3rd Degree burns entire body — INTERVAL BETWEEN ONSET AND DEATH
825 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident
20c. TIME OF INJURY: Hour 1 o. m. p. m. Month, Day, Year 5-24 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): High Point Road
20f. (City or town) Forest Hill (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF M.D.: Gerald C Palmer — CHIEF MEDICAL EXAMINER ☐ — Bel Air, Md — DATE SIGNED
EXAMINER'S NAME (Type): Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 5-24-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/27/1960
22c. NAME OF CEMETERY OR CREMATORY: Fair View
22d. LOCATION (City, town, or county): Forest Hill (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles C. Hunt — ADDRESS: Darlington, Md.
24a. REC'D BY REGISTRAR DATE: MAY 26 '60
24b. REGISTRAR'S SIGNATURE: Cirlina L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5850

CERTIFICATE OF DEATH

05814
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town) Aberdeen
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Harford
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town) 31 Aberdeen
d. STREET ADDRESS 41 Liberty Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIO — Middle LANZA — Last STRIGGLES

4. DATE OF DEATH: Month May — Day 28 — Year 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 25, 1960

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days 3 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willie James Striggles

14. MOTHER'S MAIDEN NAME: Shirley Jane Stafford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): N/A

16. SOCIAL SECURITY NO.: None

INFORMANT: Father — Address 41 Liberty St Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Apenea neonatarum — INTERVAL BETWEEN ONSET AND DEATH
762.5
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b) Prematurity
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 25, 1960, to May 28, 1960, that I last saw the deceased alive an May 28, 1960, and that death occurred at 5:15 A.M., from the causes and an the date stated abave.

ACTUAL SIGNATURE Mark Eisenstein M.D.
ADDRESS (Street, city or town, state) US Army Hospital
DATE SIGNED 28 May 1960

PHYSICIAN'S NAME (Type) MARK EISENSTEIN CAPT MC
Aberdeen Proving Ground, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/1/1960
22c. NAME OF CEMETERY OR CREMATORY: Post Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen Prov Gr Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garring — ADDRESS: Aberdeen Md.

24a. REC'D BY REGISTRAR DATE JUN 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

Nord 6/60 205024 IXVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5851 — 05815 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Street
d. STREET ADDRESS: Terry Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First FRANKLIN Middle KENNETH Last TROUT
4. DATE OF DEATH: Month May Day 12 Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-13-14
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (State or foreign country): HARFORD Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM T. TROUT
14. MOTHER'S MAIDEN NAME: MARY E. SLADE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Wm S. Trout, Street RD, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
DUE TO (c):
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I taak charge af the remains described abave, held an Autapsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted fram: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Belair, Md DATE SIGNED 5-13-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-14-1960
22c. NAME OF CEMETERY OR CREMATORY: FAWN GROVE METH.
22d. LOCATION (City, town, or county) (State): FAWN GROVE, YORK Co., PA.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth W Osburn — ADDRESS: Stewartstown, Pa.
24a. REC'D BY REGISTRAR DATE MAY 16 '60
24b. REGISTRAR'S SIGNATURE: Arthur E. Hess

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5839

CERTIFICATE OF DEATH

05816

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 21 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 401 N. Union Ave. 24
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: George — Middle: Thomas — Last: Walter

4. DATE OF DEATH: Month: 5 — Day: 3 — Year: 60 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/24/1918

9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Omer Walter

14. MOTHER'S MAIDEN NAME: Laurinda Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Ruth C. Walter — Address: 401 N. Union Ave, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac — Coronary Thrombosis
DUE TO (b): Diabetes Mellitus Chronic
DUE TO (c): Arteriosclerosis

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/2, 19 60 to 5/3, 19 60 that I last saw the deceased alive on 5/3, 19 60, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Havre de Grace Md — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): —

22b. DATE THEREOF: 5/6/60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor

22d. LOCATION (City, town or county) (State): New Bel Air Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Livingston Ray — ADDRESS: Havre de Grace, Md.

24a. RECD BY REGISTRAR DATE: MAY 9 60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G263 5/17/60 iwk

5840

CERTIFICATE OF DEATH

Reg. Dist. No. 05817

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Harford Memorial Hosp
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 601 Lewis St
d. STREET ADDRESS Havre de Grace

3. NAME OF DECEASED (Type or print): First Minnie — Middle — Last WANNER

4. DATE OF DEATH: Month 5 — Day 10 — Year 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/5/1888

9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Centerport Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Schnell

14. MOTHER'S MAIDEN NAME: Hattie Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Marvin D. Wanner — Address: 601 Lewis St., Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): A. S. C. V. D. — 2 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 27th 1960 to May 10th 1960 that I last saw the deceased alive on May 10, 1960, and that death occurred at 8 3/4 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C. Loo, M.D. — ADDRESS (Street, city or town, state): Havre de Grace Md. — DATE SIGNED: 5/10/60

PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/13/60

22c. NAME OF CEMETERY OR CREMATORY: Alsace

22d. LOCATION (City, town, or county) (State): Reading, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Penman Bros. — ADDRESS: Pa. Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE MAY 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5852 — Reg. Dist. No. 05818

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa Rural
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill Md
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Cassandra — Middle: Elizabeth — Last: Ward
4. DATE OF DEATH: Month: May — Day: 11 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Apr 22 1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Forest Hill Md
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Phillip Heck
14. MOTHER'S MAIDEN NAME: Jennie Hazlett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — none
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Russell Jealous — Address: Joppa RD. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	3 hr
DUE TO (b)	Chr. Cardio-Vascular Disease	?
DUE TO (c)		

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1934, to May 11, 1960, that I last saw the deceased alive on May 9, 1960, and that death occurred at 10:35 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill Md — DATE SIGNED: 5/11/60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 14: 1960
22c. NAME OF CEMETERY OR CREMATORY: Deer Creek Methodist
22d. LOCATION (City, town, or county) (State): Forest Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: W A Archer — ADDRESS: Benson, Md
24a. REC'D BY REGISTRAR — DATE: MAY 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Filed 11/18/63 HC

CERTIFICATE OF DEATH

5841 — 05819 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 2 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WERNERSVILLE — 75X-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: EDWARD — Middle: SAMUEL — Last: WENRICH
4. DATE OF DEATH: Month: MAY — Day: 24 — Year: 1960

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 17-1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: SAMUEL WENRICH
14. MOTHER'S MAIDEN NAME: ~~ELLEN KISSLING~~ SARAH HAIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4438
(b): Hypertensive Cardiovascular disease and — 1 yr
DUE TO
(c): Cerebral Vascular Accident — 24 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/22, 1960, to 5/24, 1960, that I last saw the deceased alive on 5/23, 1960, and that death occurred at 3 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips M.D. — ADDRESS (Street, city or town, state): Darlington Md — DATE SIGNED: 5/24/60
PHYSICIAN'S NAME (Type): Dudley Phillips — DARLINGTON, Md

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 5/28/60
22c. NAME OF CEMETERY OR CREMATORY: St. John's
22d. LOCATION (City, town, or county) (State): Wernersville Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington Son — ADDRESS: Havre de Grace Md
24a. REC'D BY REGISTRAR — DATE: MAY 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5842 **CERTIFICATE OF DEATH** 05820

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 12 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: HARFORD MEMORIAL Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CARDIFF
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MILTON Middle ROLAND Last ZELL

4. DATE OF DEATH: Month MAY Day 9 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-21-27

9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MILL OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: SLATE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES R. ZELL

14. MOTHER'S MAIDEN NAME: GRACE BAGLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-30-7915

INFORMANT: BETTY R. ZELL, Address: CARDIFF, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 13 days
DUE TO (b): Paroxysmal Hypertension — 5 years
DUE TO (c): Pheochromocytoma

224 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ refused

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 27, 1960 to May 9th, 1960 that I last saw the deceased alive on May 9th, 1960, and that death occurred at 9:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C. Loo, M.D. — ADDRESS (Street, city or town, state): Havre de Grace, Md. — DATE SIGNED: 5/9/60

PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5-13-60

22c. NAME OF CEMETERY OR CREMATORY: SLATE RIDGE

22d. LOCATION (City, town, or county) (State): DELTA, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbaugh — ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: MAY 16 '60

24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB